

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 360

63-040872
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

FILED OCT 29 1963

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia</u>		c. CITY OR TOWN <u>Sedalia</u>	
Length of stay in 1b <u>21 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boothwell Mem. Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>1842 S. Barrett</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND CLIFTON LIPPARD</u>		4. DATE OF DEATH Month Day Year <u>October 24, 1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-1888</u>
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Club.</u>	
11. BIRTHPLACE (City and state or country) <u>Rowan Co. N. Car.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Grabe Lippard</u>		13b. MOTHER'S MAIDEN NAME <u>Sallie Locke</u>	
14. NAME OF HUSBAND OR WIFE <u>Dorothy Suter Lippard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Mrs. Ralph Baird Joplin Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial wall Infarction.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>myocardial infarction, July 1963</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>22 October 1963</u> to <u>24 October 1963</u> and last saw him alive on <u>23 October 1963</u> Death occurred at <u>4:50A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Signature or title) <u>Stanley D. Fisher M.D.</u>		22b. ADDRESS <u>500 N. 16th Sedalia Missouri</u>	
22c. DATE SIGNED <u>25 Oct '63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>10-26-'63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) <u>Sedalia Mo.</u>
24. FUNERAL DIRECTOR <u>McLaughlin Bros. Sedalia Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 25, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Frank Anderson</u>			

(Licensed Embalmer's Statement on Reverse Side)

NOV 13 1963

NOV 19 1963

JAN 30 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed K. P. M. Crary

Licensed Embalmer No. 31513

P. O. Address Sedalia Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.